



Office for Oregon Health Policy & Research

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POLICY BRIEF: All-Payer, All-Claims Data Base

The current health care delivery system in Oregon does not consistently deliver high-quality care or recommended evidence-based care to Oregonians. For instance, only 40% of adults over age 50 receive recommended preventive care, and only 84% of hospitalized patients receive recommended care for myocardial infarction, congestive heart failure, and pneumonia. Yet almost \$20 billion dollars is being spent on health care in Oregon each year.

For employers who purchase health insurance, health care providers and consumers, information to compare quality, cost and efficiency is limited, making it hard to determine value. Although health care quality varies across the state and patients sometimes receive unnecessary or inadequate care, it is not currently possible to identify where unexplained variations exist in Oregon's health care system.

In order to provide a complete picture of a person's experience with the health care system, a data collection system of all health care claims paid by all payers across the state is needed. Collecting and distributing uniform and complete information would:

- Provide a basis on which to make policy decisions and target investments;
- Set standards for system improvement;
- Assess quality improvement initiatives at the community level; and
- Provide the information needed for individuals, patients and business to make appropriate and informed decisions.

A claims data collection program would collect from insurance carriers, health plans, third-party administrators, pharmacy benefit managers, Medicaid, and Medicare. The data would include eligibility information and medical, pharmacy, and dental claims.

Oregon already collects some of this information. For example, the state collects hospital use data that allows us to compare hospital quality measures and to assist disease monitoring by public health. The Quality Corporation (Q-Corp), a multi-stakeholder health care coalition, is seeking grants and health plan donations to collect and report outpatient primary care measures of quality. Q-Corp plans to work with clinicians and consumers to use the data to improve the quality of care. The proposed all-payer, all-claims data collection program is intended to complement these efforts and provide sustained data over time to help drive delivery system improvement.

Benefits of an All-Payer, All-Claims Data Collection Program

Comprehensive data about the quality and cost of health care will allow state policy-makers to monitor efforts to reduce health care costs and improve both care quality and population health. Complete data can show statewide variation in care, including whether evidence-based guidelines and best practice clinical standards are being followed and how they affect cost and quality.

Data can then be grouped by community to show variations across counties, regions, or other areas. A key advantage of using billing data is that because these data are generated automatically for every medical encounter in a standardized format (UB 04 or HCFA 1500 forms), it is relatively inexpensive to develop a data system based on these data. In addition, it does not create an additional data collection burden for the provider because data is collected from the payers (e.g., health insurance companies and third-party administrators).

Benefits for Businesses

- Helps businesses to know where they stand when compared with their peers, with respect to the cost and covered services of their health insurance policies.
- Provides access to information that gives businesses a better negotiating position.
- Allows businesses to choose insurance products for employees based on price and quality.

Benefits for Consumers

- Provides access to information, helping consumers and their health care providers make informed decisions about the effectiveness of treatments and quality of care.

Benefits for Providers

- Will not increase burden on providers, could reduce it as insurers move to single, coordinated data set.
- Supports provider efforts to design targeted quality improvement initiatives.
- Enables providers to compare their own performance with those of their peers.

Benefits for Policymakers

- Helps health care policymakers to identify communities that provide cost-effective care and learn from their successes.
- Allows for targeted population health initiatives.
- Allows for assessment of health care disparities and target interventions.
- Allows reform efforts to be evaluated so that successful initiatives can be identified and replicated.
- Identifies opportunities for further reform.

Other State Experience with All-Payer, All-Claims Data Collection

Maine has one of the oldest all-payer, all-claims databases in the nation. Data submission began in January 2003, and the first release of information was April 2005. The database is supported by a surcharge on providers and payers. The eligibility and claims data have been used to identify need for, use of and cost of care by various groups, including: service need; use and cost for chronically ill patients; need for and use of mental health medications by children; and statewide costs and geographical variation in emergency department use.

New Hampshire has implemented an all-payer, all-claims database, while Vermont and Utah are building theirs. New Hampshire has used its all-payer database to compare child health, access, prevention, care management, utilization and payments for the state's SCHIP participants and commercial insurance members. Additional studies are planned on prevalence and cost for cardiovascular disease, diabetes, chronic respiratory disease, and mental health. In Vermont, state policy makers were convinced of an all-payer, all-claims database's value because of the limitations of hospital discharge data to give a comprehensive picture of access to care, cost containment, consumer and purchaser reporting, and quality efforts.

Policy Considerations in Designing an All-Payer, All-Claims Data Base

Value Proposition. Initial implementation of this data collection program in Oregon will require an initial investment of about \$1 million, plus an annual cost to maintain. Millions of dollars are invested annually in health care in Oregon without the comprehensive information required to help patients, purchasers and policymakers make informed choices and assess the impact of policy changes. It will be important to partner with organizations that are already involved in quality improvement, such as the Q-Corp, that are critical to help translate information back to clinicians and consumers to make changes and informed choices. The state will solicit input from partners, data submitters and other stakeholders prior to formal rule-making, to align with common quality measures in use in the health care community and align with national standards, as well as work to ensure safe data storage and release.

Privacy and Access to Information. Optimal efforts to ensure safe data storage and release will be a priority. Current Oregon quality measurement efforts and those in other states have been successful in establishing privacy standards and outlining the appropriate use of data, and will serve as guides for this data collection program.

The Uninsured. The uninsured are typically not included in claims databases, although there is an interest in developing uniform methodologies for cost-effective collection of this important population's utilization data.

Health Disparities. To identify and address disparities in health care access, utilization, disease status, and quality of care, race, ethnicity, and primary language could be collected at the same time as other billing data. The data collection program would serve to inform strategies to align resources to address health care inequities.

Summary

By creating a comprehensive data collection program of all claims paid by all health care payers, Oregon will be creating a valuable tool for understanding the health care delivery system. Access to comprehensive, uniform information across populations and communities will give consumers, businesses, health care providers and policymakers a way to compare the value of the care purchased and target interventions and investments. This can shape successful strategies to provide consistent, high-quality health care to all Oregonians.

Additional Resources

- The Oregon Health Fund Board's proposal for an All-Payer All-Claims Data Collection Program (pages 41-43 of the Board's November 2008 action plan) http://www.oregon.gov/OHPPR/HFB/docs/Final_Report_112908.pdf
- National Association for Health Data Organizations. <http://nahdo.org/>
- New Hampshire Comprehensive Health Information System website includes studies performed with the state's all-payer, all-claims data and an interactive web query tool that produces eligibility and claims reports on Medicaid and commercial datasets. <http://www.nhchis.org>
- The New Hampshire Insurance Department's NH HealthCost Website allows consumers to make more informed decisions about where to seek care and what it will cost depending on their insurance plan and treating provider. <http://www.nhhealthcost.org>